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1993-94

The AMCRA Foundation

HMOs • PPOs • FMCs • UROs • IPAs

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Introduction and Acknowledgements

This Overview presents information on Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Utilization Review Organizations (UROs) between December 31, 1992 and October, 1993. The materials presented are based upon survey data contained in the AMCRA Foundation's Managed Health Care Database. The information in the Database is also published in plan-specific form in the AMCRA Foundation's *1993-94 Managed Health Care Directory*, which covers the entire managed care industry. The following pages contain a statement outlining the survey methodology used to collect the data, a definitions section, a Technical Notes section, a Summary Analysis, illustrative charts and graphs, a description of the AMCRA Foundation and the American Managed Care and Review Association (AMCRA), and a Directory order form.

Thanks are due many people who helped in the various stages of creating this Overview. John Cox supervised data collection and entry, and oversaw the renovation of the database. Kevin Moen updated the roster of organizations, coordinated the survey mailings, and organized the survey tracking system. Julianna Gonen entered the survey data, proofed the data for errors and edited the Overview. Stephan Ginion performed the computer programming for the database. Tom Vander Wal made the follow-up survey phone calls and assisted with data entry and proofreading. María Teresa Morales designed the cover and general layout, and compiled the introductory sections. Jill Arent obtained and compiled the listings from the state insurance departments and helped with data entry. Kathryn Donaldson proofread, and helped with the survey mailings. Marc Rogers wrote the surveys and the summary analysis, compiled the charts and graphs, and directed the project.

Methodology

The AMCRA Foundation's *Managed Health Care Database* contains information on Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Utilization Review Organizations (UROs), Specialty HMOs, Specialty PPOs, Foundations for Medical Care (FMCs), and Independent Practice/Physician Associations (IPAs) in the United States and its territories. Data was collected through surveys mailed to each organization by the Foundation's Research Department. Over 2,500 organizations received surveys, which were mailed in three waves, staggered by organization type due to the volume. The first mailing was sent during June and July, 1993, the second mailing to non-respondents was sent out July through August, and the third mailing was sent out August through September. Follow-up phone calls were then made to the remaining non-respondents during late August through September; data collection ended in October, 1993.

The survey forms were constructed to suit the different types of organizations queried, and were accompanied by a definitions sheet to aid in completion. Requested information ranged from covered lives by category to services offered, types of contracts, numbers of providers, accreditation, and more. Each survey also contained pre-printed demographic information for approval or correction by respondents. The roster of survey recipients in the database was updated this year through careful review of state insurance department listings of managed care organizations, and other available listings. Frequently, due to the presence of nationwide and regional managed care organizations, there was difficulty determining how to survey certain health plans. The guiding unit of analysis for determining managed health plan survey recipients was the existence of a distinct provider network. In some cases, provider networks overlapped with other plans with different coverage arrangements run by the same organization—in those instances, two plans were surveyed unless otherwise requested by the plans themselves.

In total, there are 2,211 listings in the database. There is information on virtually every HMO, PPO, and URO in the United States and its territories, which comes to 1,733 organizations. 478 more entries covering Specialty HMOs, Specialty PPOs, FMCs, POS plans, and IPAs (physician groups which contract with HMOs) are somewhat less complete due to the difficulty of tracking such organizations. These latter organizations will be updated further in the future. The analysis contained in this booklet focuses on HMOs, PPOs, and UROs, as these organizations are the most prevalent in the industry and the information in the database is most complete for them.

Definitions

Exclusive Provider Organizations (EPOs) are similar to PPOs, but only reimburse members for services rendered by providers in their network.

Foundations for Medical Care (FMCs) are physician organizations established by county or state medical societies. FMCs operate similarly to IPAs, in that they comprise physicians practicing individually or in single specialty groups. The forerunners to IPAs, FMCs provide physician and hospital services to employers. During the past few years, many FMCs have also developed HMOs, IPAs, UROs and/or PPOs.

Health Maintenance Organizations (HMOs) are health delivery systems that offer plan enrollees comprehensive health coverage for hospital and physician services for a prepaid, fixed fee. HMOs contract with or directly employ participating health care providers—i.e., physicians, hospitals, and other health professionals—and HMO members are required to choose from among these providers for all health care services.

There are five models of HMOs:

1. The **Independent Practice/Physician Association (IPA)** model HMO contracts with physicians in solo practice, and/or with independent practice/physician associations (IPAs) who, in turn, contract with their own member physicians. The majority of physicians in an IPA model HMO are in solo practice, and in many cases also have a significant number of patients who are not HMO members.

2. The **Group Model** HMO contracts with a single multi-specialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well.

3. The **Network Model** HMO contracts with more than one medical group to provide services to its members.

4. The **Staff Model** HMO employs physicians directly. The physicians are employees of the HMO, and deal exclusively with HMO members.

5. The **Mixed Model** HMO is any combination of the model types described above.

Independent Practice/Physician Associations (IPAs) are associations of physicians who practice individually or in medical groups. IPAs are created to contract with health care organizations such as HMOs and PPOs. Physicians often contract with the association while maintaining their own non-HMO practices.

A **Point-of-service (POS) option** is offered by some traditional HMOs and PPOs to its enrollees to allow for out-of-network or "out-of-plan" coverage, but with economic incentives to enrollees to use network providers, such as lower co-payments or co-insurance for their use. POS options are generally more expensive for purchasers (employers, etc.) of health care coverage.

A **Preferred Provider Organization (PPO)** is a health care benefit arrangement designed to supply services at a reasonable cost by providing incentives to its enrollees to use designated health care providers (who contract with the PPO at a discount), while also providing a lower level of coverage for services rendered by health care providers who are not part of the PPO network. Financial incentives for individuals to use preferred providers include lower co-payments or co-insurance, and maximum limits on out-of-pocket costs for in-network use. PPOs are less restrictive than HMOs in that visits to specialists are usually not dependent upon authorization by a member's primary care physician (called a gatekeeper) as they generally are by HMOs. Also, unlike HMOs, out-of-network usage is allowed by PPOs, though at a higher cost to the enrollee.

Most PPOs involve an arrangement between a panel of providers (physicians, hospitals and other health care professionals) and the purchasers of care, e.g., employers or insurance companies. The panel of preferred providers agrees to a specified fee schedule in return for preferred status, and is required to comply with certain utilization review (UR) guidelines.

PPOs are not insurers; they generally do not assume any financial risk for arranging medical services. In many cases, the risk is assumed by self-insured employers, or by another underwriter. While some PPOs are sponsored by providers, employers, or other entities, many insurance companies also own PPOs. Some of the largest insurers have developed their own PPO networks, while others lease networks from fellow insurers or form cooperative ventures with independent PPOs.

Specialty HMOs provide their members one or more limited health care benefits or services, e.g., pharmacy, vision, dental, or mental health services, and are based upon any of the five HMO model types.

Specialty PPOs are designed similarly to regular health coverage PPOs, but provide one or more limited benefits, e.g., pharmacy, vision, dental, mental health, or Workers' Compensation.

Utilization Review and Utilization Management comprise a set of procedures used by purchasers of health benefits to contain health care costs by influencing patient care decisions through assessment of the appropriateness of care prior (generally) to its provision. UM may be performed within a managed care entity, or by an external reviewer.

Utilization Review Organizations (UROs) are external reviewers who assess the medical appropriateness of a suggested course of treatment for a particular patient, thereby providing the patient and payer increased assurance of the appropriateness, value, and quality of health care services being provided. The most common form of UR, preadmission certification, is requested by the patient's physician for approval of any non-emergency admission to an inpatient facility. Other techniques include concurrent review, second surgical opinion, discharge planning, outpatient certification, case management, etc. URO services are purchased by employers, insurers, HMOs, PPOs, IPAs, or other entities responsible for all or most of the cost of the care.

Technical Notes

Enrollment Figures

Self-reported enrollment data always present technical problems. A discussion of some of these problems follows, along with caveats regarding interpretation of this summary analysis.

HMOs

HMOs generally report covered lives inclusive of dependents. This reporting method appears to be used by all HMOs, making interpretation of HMO enrollment figures fairly straightforward. Some caveats are relevant to HMOs, however, and are covered in the "State Enrollment Percentages" and "Categorical Enrollments" sections below.

PPOs

PPOs generally report enrollment data in terms of covered employees, then utilize a multiplier to arrive at a total covered lives figure which includes dependents. This multiplier varies by organization, and even within organization according to the category of enrollment being analyzed. The insurance industry standard (developed by the Health Insurance Association of America) is 2.3, which means that for every covered PPO employee listed in this analysis, there would be an estimated 2.3 covered lives if one were to include spouses, children, and other dependents.

Traditionally, the industry uses multipliers when speaking in terms of covered PPO lives, but because of the variation in multipliers used by the different PPOs, the survey instrument requested PPO enrollments exclusive of dependents, in order to allow a more uniform multiplier to be used overall. Several PPOs did not supply figures exclusive of dependents, however, and could not do so upon further request. For this reason, the total enrollment figures, exclusive of dependents, which are listed in the summary analysis are likely somewhat inflated.

PPO enrollment data are also difficult to interpret for other reasons. There are many nationwide PPO networks with very large enrollment figures. Some of these networks have many investors, with each investor doing business as a PPO offering health coverage, using primarily the same provider networks. Because of this, enrollment figures are sometimes reported by the individual investors' companies and by the network itself, resulting in double-counting. Great efforts were made to avoid such double-counting, but sometimes it was impossible to obtain definitive responses.

UROs

Eligible covered lives for UROs indicates the number of individuals covered by health plans with which that organization has contracts to perform utilization review and/or utilization management. Only a small percentage of eligible covered lives is ever reviewed, naturally, because not everyone utilizes health insurance in a given year. The total number of covered URO lives industry-wide is an extremely high number, partly because utilization review companies have overlapping enrollment. Some individuals may be covered under two health plans (e.g., spouses), some may be covered under Workers' Compensation by one URO, automobile accident UR by another, and mental health benefits by a third URO, etc.

State Enrollment Percentages

For both HMOs and PPOs there are instances in which national or regional organizations reported composite enrollment figures for all of their plans, with several, but not all of their individual plans also responding. The composite figure would then appear in the state in which the headquarters is located; the individual plan enrollment figures would be removed (all other individual plan information would remain). In such cases, an attempt was made to get a plan-by-plan enrollment breakdown from the parent organization. This approach was often successful, but for several organizations it was not. The net effect is an increase or decrease in some statewide enrollment figures in the summary analysis, due to the "lumping" of enrollment figures for a regional or national plan in one location. In cases in which the effect was thought to be significant, state HMO or PPO penetration figures were not calculated in the summary analysis.

Categorical Enrollments

Many organizations reported total enrollment figures without breaking them down by categories, such as Medicare, Medicaid, Workers' Compensation, employers, etc. The enrollment breakdown charts in the summary analysis, therefore, have a category labeled "other / no breakdown." This "other / no breakdown" category may contain some of the enrollment which would normally be divided among the other categories. The most important implication of this problem is that for PPOs, some Workers' Compensation covered lives would be impossible to separate from regular health coverage figures, again inflating PPO covered lives.

Summary Analysis

This analysis focuses on HMOs, PPOs, and UROs, which comprise the largest part of the managed care industry. Because these three are the most prevalent types of managed care organizations, they are likely the most accustomed to supplying the kind of data the Foundation's survey requested. For that reason, the Foundation's database is most complete for these three organization types.

Enrollment

Table 1 below exhibits enrollment data for HMOs, PPOs, and UROs. (Enrollment figures for PPOs are exclusive of Workers' Compensation enrollment. For UROs, Workers' Comp. has been left in the covered lives figures.)

	Covered Lives December 31, 1992	Number of Plans / Companies December 31, 1992	Number of Plans / Companies October, 1993
HMOs	42,112,339	554	566
PPOs	50,447,748	879	895
UROs	302,353,138	271	272

Table 1. HMO, PPO, and URO Covered Lives, and Numbers of Plans / Companies

The survey requested enrollment information as of December 31, 1992, and as of March 31, 1993. Based upon the percentage change in average enrollment from December 31, 1992 to March 31, 1993 for all plans or companies which reported both sets of enrollment figures, the following estimates have been made for March 31, 1993 overall enrollments. (For PPOs, Workers' Compensation enrollment has been excluded from the calculation, in keeping with the figures above. For UROs, Workers' Comp. has been left in the covered lives calculations.)

	Estimated Covered Lives March 31, 1993	
HMOs	44,302,181	
PPOs	54,433,120	(excluding Workers' Comp.)
UROs	323,820,211	(including Workers' Comp.)

Table 2. Estimated HMO, URO, and PPO Covered Lives, March 31, 1993

Point of Service (POS) Plans, POS Options, & EPO (Exclusive Provider) Options

POS Plans

Ninety plans identified themselves as specifically Point of Service (POS) plans. These plans employ a more restrictive arrangement for the use of providers by enrollees than do PPOs. Such plans do allow for the use of non-network providers, but at a lower level of reimbursement to enrollees for their use than do PPOs. (See "Definitions" for further explanation of POS.)

	December 31, 1992	March 31, 1993
Lives	603,990	856,307
	December 31, 1992	**October, 1993**
Plans/Companies	79	90

Table 3. POS Plans - Covered Lives and Enrollment

Point of Service (POS) Option

Many HMOs and PPOs offer a point of service *option* as one of their packages available to purchasers. Over 72% of all HMOs responded to the survey's point of service questions, which revealed that for HMOs, there are at least 186 plans (32.9%) in the country which had point of service enrollment as of March 31, 1993. At least 38 HMOs (6.7%) have added a POS option since March 31, 1993, and at least 65 (11.5%) intend to do so within the next two years.

HMO POS Covered Lives December 31, 1992	HMO POS Covered Lives March 31, 1993
at least... 2,536,413 (6% of all HMO enrollment)	at least... 3,095,667

Table 4. HMO Point of Service Covered Lives

Over 77% of PPOs answered the survey's POS-related question, revealing that at least 416 PPOs (46.5%) offered a point of service option as of October, 1993.

PPO Exclusive Provider Option

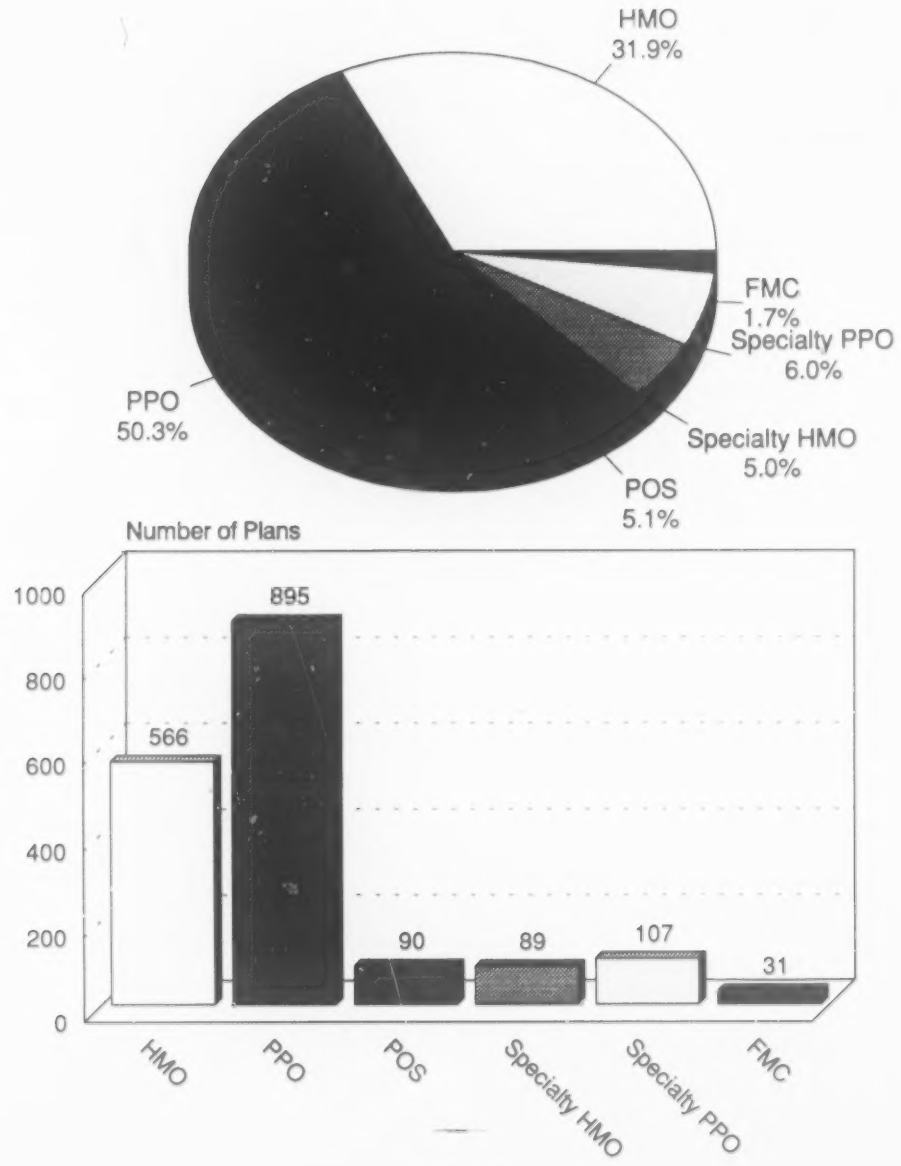
An exclusive provider option offers no coverage for out-of-network providers. With over 77% of PPOs responding to this question, as of October, 1993, at least 281 PPOs (31.4%) offered an exclusive provider option.

Charts and Graphs

Several illustrative charts and graphs follow which present more of the information contained in the Foundation's database.

Plan Types as % of Industry

(As of October 1993)



The figures contained in these graphs should be interpreted cautiously, as the information for plans other than HMOs and PPOs is less complete due to difficulty in tracking these organizations (see Methodology section above). POS here refers to plans that are exclusively POS; some HMOs and PPOs also offer a POS option to their enrollees (see Summary Analysis above).

Source: AMCRA Foundation Managed Health Care Database

HMOs: Numbers and Percentages of Plans and Enrollees

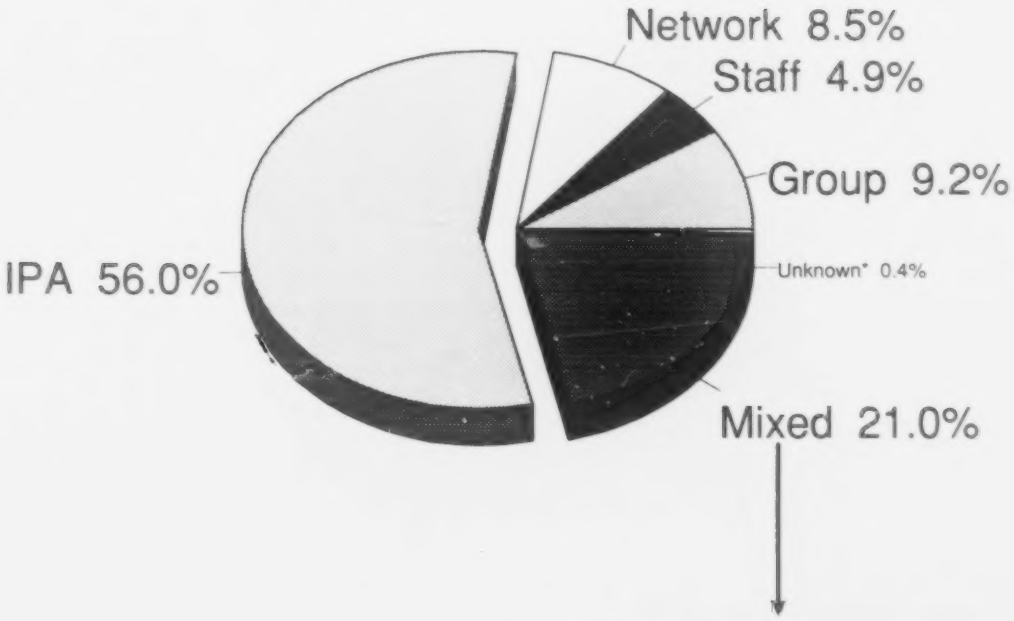
(1992-1993)

Model Type	No. of Plans - 12/31/92	*% of Plans - 12/31/92*	No. of Plans - 10/93	*% of Plans - 10/93*	No. of Enrollees - 12/31/92	*% of Enrollees - 12/31/92*
IPA	306	*55.2%*	317	*56.0%*	15,912,286	*37.8%*
Group	51	*9.2%*	52	*9.2%*	9,013,249	*21.4%*
Network	48	*8.7%*	48	*8.5%*	3,429,570	*8.1%*
Staff	28	*5.1%*	28	*4.9%*	1,742,485	*4.1%*
Mixed	119	*21.5%*	119	*21.0%*	12,014,749	*28.5%*
Unknown	2	*0.4%*	2	*0.4%*		
Total	**554**	***100%***	**566**	***100%***	**42,112,339**	***100%***

Source: AMCRA Foundation Managed Health Care Database

Model Types as % of HMO Plans

(As of October 1993)



92 HMOs identified themselves as being less than 100% of a particular model type:

	No. of plans between 1% and 50%, and 51% and 99% of a model type:	
	1-50%	51-99%
Model type		
IPA	43 plans	27 plans
Network	26 plans	20 plans
Staff	26 plans	16 plans
Group	30 plans	13 plans

For 27 "mixed" plans, the model combinations are known, but the amounts of each type are unknown:

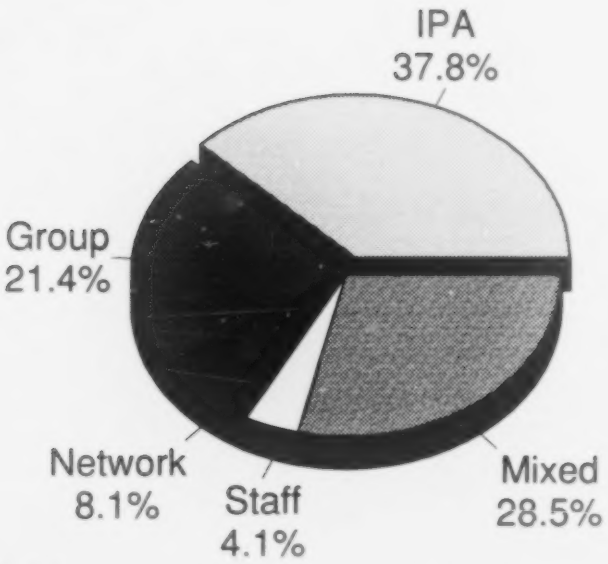
IPA and Network	9
Network and Staff	5
IPA and Group	4
IPA and Staff	3
IPA, Group, Staff	2
Group and Network	1
Group, Staff	1
IPA, Network, Staff	1
Group, Network, Staff	1

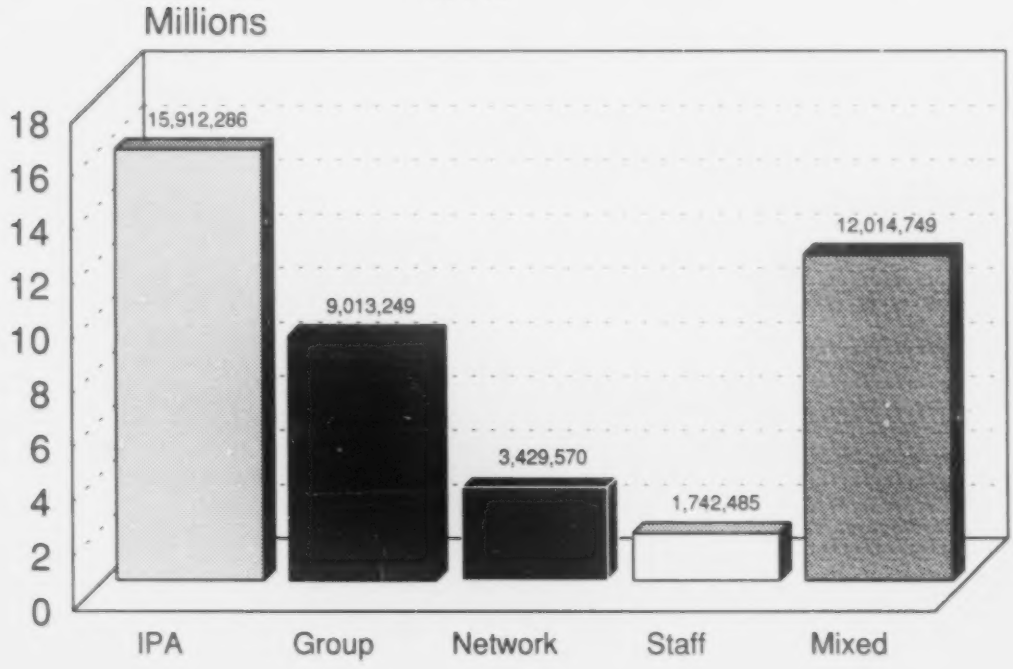
*Information on model type is unknown for 2 HMOs.

Source: AMCRA Foundation Managed Health Care Database

HMO Enrollment by Model Type

(As of December 31, 1992)

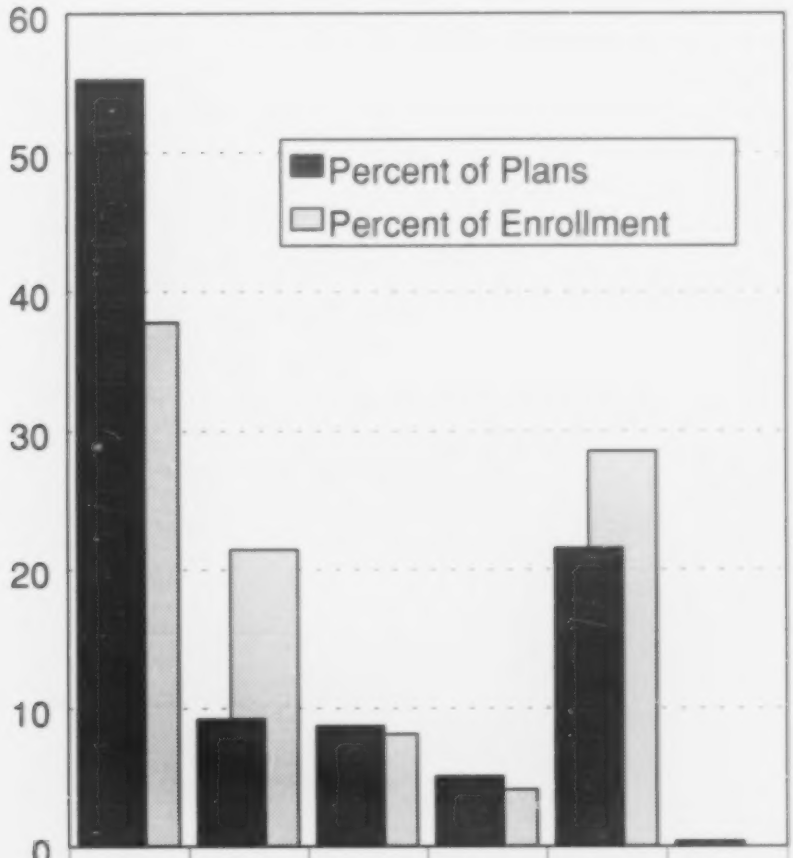




Source: AMCRA Foundation Managed Health Care Database

HMO Plan & Enrollment Percentages by Model Type

(As of December 31, 1992)



	IPA	Group	Network	Staff	Mixed	Unknown
Percent of Plans	55.2	9.2	8.7	5.1	21.5	0.4
Percent of Enrollment	37.8	21.4	8.1	4.1	28.5	

Source: AMCRA Foundation Managed Health Care Database

HMO Enrollment by Category

(1992 - 1993)

Enrollment Category	As of Dec. 31, 1992	As of March 31, 1993*
Employers (non-gvmnt.)	53.7%	51.4%
State government	5.8%	4.6%
FEHBP	4.3%	3.4%
CHAMPUS	+	+
Medicare	3.3%	3.4%
Medicaid	2.9%	3.8%
Workers' Compensation	+	0.1%
Other / no breakdown available	29.9%	33.2%
TOTAL	100%	100%
Amount above in point of service	6.0%	8.6%

*Data for March 31, 1993 was less complete than for December 31, 1992.
+Less than 0.1%

Source: AMCRA Foundation Managed Health Care Database

HMO Enrollment by Plan Size

(As of December 31, 1992)

Plan Enrollment Size	Number of Plans	Percent of Plans	Number of Enrollees	Percent of Enrollees
0 - 19,999*	186	33.6%	1,763,182	4.2%
20,000 - 49,999	179	32.3%	5,803,987	13.8%
50,000 - 99,999	79	14.3%	5,796,791	13.8%
100,000 - 199,999	67	12.1%	9,232,786	21.9%
200,000 - 299,999	18	3.2%	4,348,062	10.3%
300,000 - 499,999	18	3.2%	6,968,369	16.5%
500,000 - 999,999	5	0.9%	3,666,891	8.7%
1,000,000 -	2	0.4%	4,532,271	10.8%
TOTALS	554	100.0%	42,112,339	100.0%

*Enrollment figures for some plans with zero enrollment were stated by national or regional headquarters, enrollment for several plans was actually zero, and enrollment for a few plans is unknown.

Source: AMCRA Foundation Managed Health Care Database

HMO Enrollment as a Percentage of State and U.S. Territorial Populations

State or Territory	No. Plans 10/93	No. Plans 12/31/92	HMO Enrollment 12/31/92	HMOs as Percent of Population
Alabama	8	8	259,465	6.3%
Alaska	0	0	0	0.0%
American Samoa	0	0	0	0.0%
Arizona	13	13	930,448	24.3%
Arkansas	5	4	64,773	2.7%
California	44	44	10,193,728	33.0%
Colorado	14	14	783,477	22.6%
Connecticut	12	12	588,470	17.9%
Delaware	6	6	135,377	19.6%
Dist. of Columbia	3	3	148,680	25.2%
Florida	36	36	2,105,674	15.6%
Georgia	10	8	475,614	7.0%
Guam	3	3	75,069	56.4%
Hawaii	7	7	343,359	29.6%
Idaho	1	1	18,489	1.7%
Illinois	27	25	2,054,439	17.7%
Indiana	14	14	383,862	6.8%
Iowa	4	4	111,994	4.0%
Kansas	10	10	170,970	6.8%
Kentucky	5	5	346,127	9.2%
Louisiana	10	10	330,053	7.7%
Maine	2	2	52,892	4.3%
Maryland	16	16	1,233,925	25.1%
Massachusetts	19	18	2,201,898	36.7%
Michigan	17	17	1,694,165	18.0%
Minnesota	10	10	1,338,820	29.9%
Mississippi	1	0	*	0.0%
Missouri	17	17	748,074	14.4%
Montana	1	1	10,298	1.2%
Nebraska	5	5	101,504	6.3%
Nevada	6	4	140,924	10.6%
New Hampshire	3	3	150,328	13.5%
New Jersey	10	10	964,290	12.4%
New Mexico	5	5	249,972	15.8%
New York	35	35	3,387,560	18.7%
North Carolina	10	10	431,000	6.3%
North Dakota	2	2	6,070	1.0%
N. Mariana Islands	0	0	0	0.0%
Ohio	36	34	1,671,525	15.2%
Oklahoma	7	7	224,682	7.0%
Oregon	8	8	887,200	29.8%
Pennsylvania	19	18	2,521,858	15.8%
Puerto Rico	1	1	0	0.0%
Rhode Island	3	3	169,444	16.9%
South Carolina	4	4	102,766	2.9%
South Dakota	1	1	20,593	2.9%
Tennessee	11	11	249,874	5.0%
Texas	26	26	1,801,911	10.2%
U.S. Virgin Islands	0	0	0	0.0%
Utah	9	9	515,178	28.4%
Vermont	1	1	*	*
Virginia	11	11	398,690	6.3%
Washington	10	10	814,705	15.9%
West Virginia				0.0%
Wisconsin	28	28	1,121,016	22.4%
Wyoming	0	0	0	0.0%
U.S. TOTAL	**566**	**554**	**42,112,339**	**16.3%**

* Vermont's enrollment is included in the HMO's NY home office figures; Mississippi's HMO began in 1993.

Notes: (1) All state (and D.C.) population figures are for 1992, from the U.S. Dept. of Commerce, Bureau of the Census; population figures for American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands are for 1990, from the same source. (2) HMO enrollment for each state was determined by primary service area of HMO, not office location.

Source: AMCRA Foundation Managed Health Care Database

25 Largest Individual HMOs

(As of December 31, 1992)

HMO Name	City	State	Enrollment
Kaiser Foundation Health Plan, Inc./So. California	Pasadena	CA	2,273,888
Kaiser Foundation Health Plan, Inc./No. California	Oakland	CA	2,258,383
Health Net	Woodland Hills	CA	882,332
Health Insurance Plan of Greater NY	New York	NY	872,561
PacifiCare of California	Cypress	CA	742,025
U.S. Healthcare (Pennsylvania)	Blue Bell	PA	587,766
HealthPartners	Minneapolis	MN	582,207
Group Health Cooperative of Puget Sound	Seattle	WA	475,124
Foundation Health	Rancho Cordova	CA	450,000
CaliforniaCare	Woodland Hills	CA	448,501
Harvard Community Health Plan	Brookline	MA	445,182
Blue Choice	Rochester	NY	435,749
U.S. Healthcare (New Jersey)	Fairfield	NJ	418,220
Health Alliance Plan of Michigan	Detroit	MI	404,732
Keystone Health Plan East	Philadelphia	PA	401,001
Kaiser Foundation Health Plan of the NW	Portland	OR	377,844
FHP, Inc.	Cerritos	CA	364,403
HMO Blue	Boston	MA	362,247
TakeCare of California	Concord	CA	360,094
Medica Choice	Minneapolis	MN	358,011
HMO Illinois	Chicago	IL	357,558
Bay State Health Care, Inc.	Cambridge	MA	344,245
QualMed Plans for Health	Oakland	CA	337,638
M.D. IPA Health Plan	Rockville	MD	324,540
CIGNA Medical Group Healthplan	Glendale	CA	303,280

Source: AMCRA Foundation Managed Health Care Database

PPO Enrollment and Number of Plans

(1992 - 1993)

Enrollment* December 31, 1992	50,447,748
Number of PPOs December 31, 1992	879
Estimated* Enrollment March 31, 1993	54,433,120
Number of PPOs October, 1993	895

*See the *Technical Notes* section for a discussion of PPO enrollment, and the beginning of the *Summary Analysis* for an explanation of March 31, 1993 enrollment estimates.

Source: AMCRA Foundation Managed Health Care Database

PPO Enrollment by Category

(1992 - 1993)

Enrollment Category	As of Dec. 31, 1992	As of March 31, 1993*
Self-Insured employers	8.0%	9.9%
Insurance companies	11.7%	10.5%
Third Party Administrators (TPAs)	5.8%	3.7%
State government	2.2%	1.8%
FEHBP	1.7%	1.8%
CHAMPUS	0.1%	0.1%
Medicare	0.1%	0.1%
Medicaid	+	0.1%
Workers' Compensation	44.2%	46.3%
Other / no breakdown available	26.2%	25.8%
TOTAL	100%	100%

*Data for March 31, 1993 was less complete than for December 31, 1992.
+Less than 0.1%

Source: AMCRA Foundation Managed Health Care Database

PPO Enrollment (less dependents) as a % of State and U.S. Territorial Populations

State or Territory	No. Plans 10/93	No. Plans 12/31/92	PPO Enrollment 12/31/92	PPOs as Percent of Population
Alabama	27	26	1,094,952	26.5%
Alaska	3	3	5,176	0.9%
American Samoa	0	0	0	0.0%
Arizona	26	26	5,274,414	*
Arkansas	4	4	9,704	0.4%
California	77	77	10,752,067	34.8%
Colorado	33	33	1,317,134	38.0%
Connecticut	10	9	75,036	2.3%
Delaware	4	4	68	*
Dist.of Columbia	9	9	678,717	*
Florida	61	59	3,607,528	26.7%
Georgia	26	26	671,442	9.9%
Guam	0	0	0	0.0%
Hawaii	3	3	404,449	+
Idaho	1	1	0	0.0%
Illinois	33	33	4,956,671	42.6%
Indiana	24	23	2,425,270	42.8%
Iowa	9	9	189,464	6.7%
Kansas	17	16	405,434	16.1%
Kentucky	11	10	40,426	1.1%
Louisiana	28	28	724,036	16.9%
Maine	5	5	6,616	0.5%
Maryland	17	17	771,254	15.7%
Massachusetts	21	21	334,984	5.6%
Michigan	24	22	1,353,358	14.3%
Minnesota	15	14	777,972	17.4%
Mississippi	6	5	21,649	0.8%
Missouri	21	21	675,716	13.0%
Montana	0	0	0	0.0%
Nebraska	8	8	558,514	*
Nevada	13	13	275,898	20.8%
New Hampshire	6	6	38,100	3.4%
New Jersey	17	17	308,689	4.0%
New Mexico	5	5	36,902	2.3%
New York	20	19	1,947,263	10.7%
North Carolina	23	23	654,086	9.6%
North Dakota	0	0	0	0.0%
N. Mariana Islands	0	0	0	0.0%
Ohio	44	44	1,096,416	10.0%
Oklahoma	14	14	193,977	6.0%
Oregon	9	9	416,846	14.0%
Pennsylvania	50	49	974,783	8.1%
Puerto Rico	1	1	55,000	1.5%
Rhode Island	2	2	13,828	1.4%
South Carolina	10	10	323,930	9.0%
South Dakota	1	1	7,316	1.0%
Tennessee	29	29	1,359,357	27.1%
Texas	62	62	2,706,441	15.3%
U.S. Virgin Islands	0	0	0	0.0%
Utah	11	9	404,523	22.3%
Vermont	1	1	0	*
Virginia	14	13	581,986	9.1%
Washington	21	21	1,395,219	27.2%
West Virginia	4	4	36,780	2.0%
Wisconsin	15	15	488,357	9.8%
Wyoming	0	0	0	0.0%
U.S. TOTAL	**895**	**879**	**50,447,748**	**19.5%**

* In this analysis, an attempt was made to report enrollment figures and to list plans according to the major service area for each plan. Some plans reported all of their figures only in regional or state headquarters, which skewed the analysis, particularly for the states in which those headquarters are located. When the enrollment for a state is greatly affected by such reporting problems, the percentage penetration has not been calculated.

+ Some plans supplied enrollment figures inclusive of dependents. No percentage was calculated if the effect were thought to impact the state's figure significantly.

Notes: (1) All state (and D.C.) population figures are for 1992, from the U.S. Dept. of Commerce, Bureau of the Census; population figures for American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands are for 1990, from the same source. (2) Caution is advised in interpreting these penetration rates due to overlapping state service areas.

Source: AMCRA Foundation Managed Health Care Database

PPO Characteristics
(As of October 1993)

Each PPO was asked whether or not each of the following characteristics pertains to its plan. These figures represent approximately 76% of the PPO industry:

Characteristic	Number	Percentage Responding Yes
Rent out provider network	288	42.5%
Provider discounts	504	74.3%
Physicians are at financial risk	188	27.7%
Hospitals are at financial risk	193	28.5%
Provider credentialling	586	86.4%
Provider profiling	496	73.2%
Physician peer review	487	71.8%
Gatekeeper	276	40.7%
Administer claims	411	60.6%
PPO is at risk	35	5.2%
Inpatient prospective UR/UM	625	92.2%
Inpatient concurrent UR/UM	597	88.1%
Inpatient retrospective UR/UM	531	78.3%
Outpatient prospective UR/UM	550	81.1%
Outpatient concurrent UR/UM	438	64.6%
Outpatient retrospective UR/UM	498	73.5%
Provide routine management reports to payers	530	78.2%
Quality assurance program	549	81.0%
Catastrophic case management program	564	83.2%

Source: AMCRA Foundation Managed Health Care Database

HMO, PPO, and URO Ownership

(As of October 1993)

Owner Type	Number of HMOs	Percent of HMOs	Number of PPOs	Percent of PPOs	Number of UROs	Percent of UROs
Insurance company	138	24.4%	388	43.4%	10	3.7%
National managed care co.	95	16.8%	71	7.9%	10	3.7%
BlueCross BlueShield	75	13.3%	60	6.7%	12	4.4%
Hospital or hospital alliance	44	7.8%	68	7.6%	7	2.6%
Physician / hospital joint venture	19	3.4%	53	5.9%	4	1.5%
Physician / medical group	22	3.9%	24	2.7%	12	4.4%
Physician(s)	1	0.2%	3	0.3%	5	1.8%
Independently owned	75	13.3%	115	12.8%	91	33.5%
Third Party Administrator (TPA)	0	0.0%	19	2.1%	10	3.7%
HMO			20	2.2%	0	0.0%
Cooperative	12	2.1%	0	0.0%	0	0.0%
University	6	1.1%	0	0.0%	0	0.0%
Local non-profit	8	1.4%	0	0.0%	4	1.5%
Publicly held corporation	11	1.9%	0	0.0%	8	2.9%
Other	42	7.4%	56	6.3%	41	15.1%
Unknown	18	3.2%	18	2.0%	58	21.3%
TOTALS	**566**	**100.0%**	**895**	**100.0%**	**272**	**100.0%**

Source: AMCRA Foundation Managed Health Care Database

URO Eligible Lives and Number of Companies

(1992 - 1993)

Eligible Lives* December 31, 1992	302,353,138
Number of UROs December 31, 1992	271
Lives Reviewed* in 1992	12,024,379
Estimated Eligible* Lives March 31, 1993	323,820,211
Number of UROs October 1993	272

* See the Technical Notes section for a discussion of URO "eligible lives" and "lives reviewed," and the beginning of the Summary Analysis for an explanation of March 31, 1993 enrollment estimates.

Source: AMCRA Foundation Managed Health Care Database

URO Services Reviewed

(As of October 1993)

Over 64% of UROs provided information on the services they review...

Services Reviewed	Percentage Which Review
Inpatient medical/surgical	83.4%
Outpatient medical/surgical	80.6%
Chemical dependency/substance abuse	83.4%
Inpatient mental health	88.0%
Outpatient mental health	70.3%
Skilled nursing	56.6%
Workers' Compensation	62.3%
Rehabilitation	69.1%
Podiatric	44.0%
Home health	62.8%
Nursing home	45.7%
Dental	26.3%
Chiropractic	50.3%
Drug utilization	30.8%
Auto/general liability	18.3%

Source: AMCRA Foundation Managed Health Care Database

About the AMCRA Foundation and AMCRA

AMCRA Foundation

The AMCRA Foundation is the nonprofit research and educational arm of AMCRA, the American Managed Care and Review Association. The Foundation's goal is to gather information on the managed health care industry and disseminate it to both the public and to those within the industry.

The Foundation's educational activities include two dynamic one-year certification programs, The Executive Leadership Program (ELP) and The Executive Leadership Program for Medical Directors (ELP-MD). These programs develop leadership and management skills for managed care industry professionals and medical directors through academic and experiential components. Each participant (fellow) is paired with an experienced chief executive officer or medical director (mentor), which includes a one-week site visit to the mentor's organization. The academic component includes intensive seminars, two national managed care conferences, and a program at Northwestern University. Upon completion of the entire program, fellows become Certified Managed Care Executives (CMCEs).

The Foundation's research activities include a yearly survey of all managed health care organizations in the nation, and subsequent publication of the *Managed Health Care Directory*. From the survey data, a summary analysis is also published. In addition, the Foundation maintains a library of important managed care-related books, journals, studies, reports, and media articles, conducts a yearly survey of the industry on a timely topic, and commissions occasional studies of importance to managed care.

AMCRA

What is AMCRA?

AMCRA (the American Managed Care and Review Association) is the national trade association representing over 500 managed care organizations providing health care services to over 75 million Americans. AMCRA represents the full spectrum of managed care organizations—including HMOs, IPAs, PPOs, UROs, FMCs, and HIOs—providing Americans with a choice of health care plans that emphasize the appropriate use of health care services and facilities, resulting in high quality health care at an affordable cost. AMCRA also includes a broad-based membership of allied health care professionals who provide services to the managed care industry.

Background

AMCRA was founded in 1971 as the American Association of Foundations for Medical Care. The association promoted utilization review as a means of providing quality health care and containing health care costs, and successfully lobbied for the passage of the HMO Act. In 1982, the association changed its name to the American Medical Care and Review Association to better reflect its membership base. As the managed care industry grew, AMCRA kept pace and changed its name a third time to the American Managed Care and Review Association.

AMCRA provides information for members, government, and other associations on a wide variety of topics, including state and federal legislative issues, and industry trends and statistics.

Membership

AMCRA has two categories of membership: active and associate. Reflecting the development of the industry, AMCRA has more than doubled its membership in the last ten years. Members range from single-site organizations to national managed care companies.

National Health Policy
AMCRA is widely recognized as a resource for the Administration, legislators, policy makers, and the managed care industry. The office of National Health Policy provides direction and leadership to AMCRA members on national health care legislation, regulation, and reform issues.

State Health Policy
The office of State Health Policy provides members with accurate, timely information, and assistance on managed care issues in the states. An active membership and flexible internal structure allows AMCRA State Health Policy staff to provide a rapid response to developing legislation and to influence state health policy.

Public Affairs
The office of Public Affairs educates AMCRA members, Members of Congress and their staffs, the Administration, and the media on issues regarding public health policy. Working with association members and health care industry coalitions, the office of Public Affairs develops strategies and tactics advocating managed care solutions to health care reform.

Publications
- ***The Monitor***, AMCRA's newsletter
- ***State Health Policy Updates***, published monthly
- ***National Health Policy Updates***, published monthly

Research
AMCRA's Research Department provides:
- original research and studies on topics of importance to the industry
- fact sheets on HMOs, PPOs, and UROs
- a database retrieval system on managed care topics

Education
AMCRA's conferences and other educational programs address current issues of importance to the health care community. Educational programs include:
- Annual Managed Care Conference & Exhibition
- Mid-Year Managed Care Summit & Exhibition
- Managed Behavioral Health Conference
- Utilization Management Conference
- CEO/COO Roundtable
- Specialty seminars

Total Kentucky

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Louisville, KY 35605

Phone: 206/934-7661 Fax: 206/933-4727
Contact: Joan Spright
Executive: Alex Campbell
Medical Dir.: Viki Hollings
Oper. date: 05/86 If no POS, will add within 2 years?
Owner type: Employer or Employer Group
Owner: Health, Inc.
Model type - IPA: 100% Network: % Group: % Staff: %
Medicare contracts:
Medicaid contracts:
UR performed: Internally
Accredited by:
Use pharm. formulary? Y Tax status: For profit

Covered Lives	As of 12/31/92	As of 3/31/93
Employers (non-gov't.)	1,798	2,214
FEHBP	8,385	10,236
State gov't.		
CHAMPUS		
Medicare		
Medicaid		
Workers' Comp.		
Other		
Total	10,183	12,450
Amount above in POS	8,385	

Contracting providers - Hospitals:	58
Primary care physicians:	744
Specialists:	2,223
Total physicians:	2,967
Ancillary/allied health professionals:	813

Service area - States: KY; Counties: KY: Autauga, Bibb, Clarke, Coosa, Dallas, Greene, Lauderdale, Macon, Monroe, Pickens, Tallapoosa, Wilcox, Baldwin, Bullock, Coffee, Crenshaw, Elmore, Hale, Lawrence, Madison, Montgomery, Shelby, Tuscaloosa, Barbour, Calhoun, Colbert, Cullman, Escambia, Jackson, Limestone, Marshall, Morgan, St. Clair, Walker, Blount, Chilton, Conecuh, Dale, Franklin, Jefferson, Lowndes, Mobile, Perry, Ralladega, Washington

The AMCRA Foundation's *1993-94 Managed Health Care Directory*

of over 2,100 HMOs, PPOs, UROs, FMCs, IPAs, and other Managed Health Care Organizations.

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